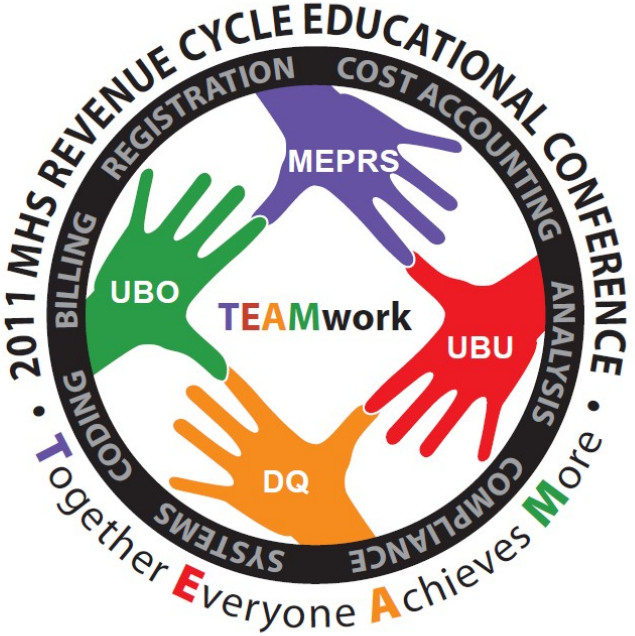


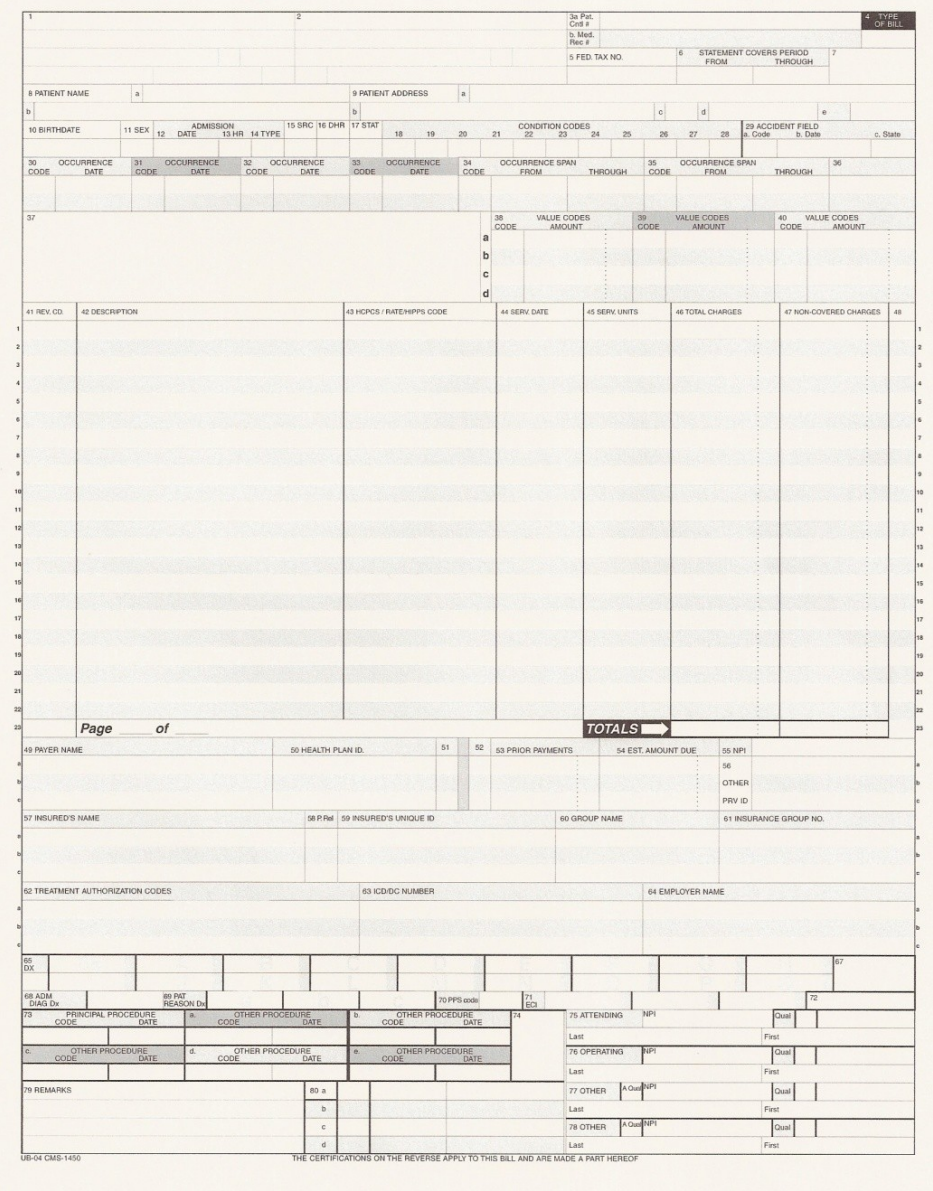
Title: **How Revenue Codes & POA Affect Billing**

Session: **W 1-1330**

Objectives

- Understand Occurrence and Condition Codes
- Understand how Revenue Codes are used for claim payment
- How Modifiers work and how they impact claims financially
- What is a POA (Present on Admission) Indicator?
- How is it linked to MS-DRGs?
- Why does it affect the MHS?
- When is it required for billing?
- How is the MHS complying with this requirement?

The UB-04 Form



Occurrence Codes

What are Occurrence Codes for Billing?

- Field Locators 31–36 are used for Occurrence Codes and Dates
- The field has room for a two-digit code (ex: 01) and a date (date of the occurrence)
- The date must fall within the statement coverage date
- FL 29 is used to identify the state where the accident occurred (two-digit state code or three-digit country code)

Occurrence Code Categories

- There are 99+ identified Occurrence Codes that are broken into 4 categories:
  1. Accident-Related Codes
  2. Medical Condition Codes
  3. Insurance-Related Codes
  4. Service-Related Codes

Occurrence Code Examples

Accident/Medical Codes:

- 01 - Accident/Medical Coverage
- 02 - No-Fault Insurance Involved – Including Auto Accident/Other
- 03 - Accident/Tort Liability
- 04 - Accident - Employment Related
- 05 - Accident/No Medical or Liability Coverage
- 06 - Crime Victim

Medical Condition Codes:

- 09 - Start of Infertility Treatment Cycle
- 10 - Last Menstrual Period
- 11 - Onset of Symptoms/Illness

(Extracted from CMS Manual https://www.cms.gov/transmittals/downloads)

Occurrence Code Examples

Examples of Insurance-Related Codes:

- 16 - Date of Last Therapy
- 17 - Date Outpatient Therapy Plan Established/Last Reviewed
- 22 - Date Active Care Ended

(Extracted from CMS Manual https://www.cms.gov/transmittals/downloads)

Occurrence Code Examples

Service-Related Codes:

- 40 - Scheduled Date of Admission – This code and corresponding date indicate when the patient will be admitted as an inpatient to the hospital
- 42 - Date of Discharge – This code and corresponding date indicate actual discharge date
- A3 - Benefits Exhausted – This code indicates the last date for which benefits are available for the payer listed in FL 50, line A, and after which no payment can be made

(Extracted from CMS Manual https://www.cms.gov/transmittals/downloads)

Condition Codes for Billing

When do we use Condition Codes for billing?
These codes identify the primary payer for the claim

Examples:

01 Military Service-Related – Indicates that the medical condition being treated was incurred during military service. Coordinate coverage with the Department of Veterans Affairs

02 Condition Is Employment-Related – Indicates that the patient alleges the medical condition or injury causing this episode of care is due to employment environment or events (Workers' Compensation, etc.)

Payer Requirements for Revenue Centers

Why do third-party payers require revenue codes?

- Revenue codes tell the story of “where” the service was performed
- The four-digit number has a description (in English)
- There are short descriptions (32 characters with abbreviations) and long descriptions
- Only short descriptions appear on the UB-04 due to computer limitations
- Each CPT and HCPCS code has a range of revenue codes that are payer-acceptable
  - Example: Brain surgery may only be done in certain locations due to patient safety – 360 would designate this surgery was done in the OR (as opposed to 510 – clinic setting)

Billing Requirements Differ by Payer

Why do different payers require different things on a claim?

- Reimbursement models, such as APC (Ambulatory Payment Classifications) – Medicare's Outpatient Prospective Payment System – have a requirement that the revenue code must be listed on the claim for where the service occurred
  - Example: A portable chest x-ray (typically done in the radiology department) can also be done in the ER
- This payer requires that 450 (ER) be listed as the revenue code associated with the description and CPT for this service

Note: Currently, MHS does not bill using APC methodology

Billing Requirements Differ by Payer

- Managed Care Contracts and Agreements, which commercial hospitals enter into with insurance payers, can also drive the billing requirements
- Reimbursement for inpatient stays – can be paid per diem, DRG or MS-DRG, or case rate
- Pay outpatient at a percentage of charges
- Require certain services to have specific revenue codes
  - Example: Drugs in general 250 revenue code can sometimes be bundled into the pricing
  - However, drugs in 636 revenue code can be eligible for separate payment

Drilling Down for Revenue Codes

- Breaking down Clinic Revenue Codes:
  - 0510 – Clinic – General
  - 0511 – Chronic Pain Center
  - 0512 – Dental Clinic
  - 0513 – Psychiatric Clinic
  - 0514 – OB/GYN Clinic
  - 0515 – Pediatric Clinic
  - 0517 – Family Practice Clinic
  - 0519 – Other Clinic

Linking the Revenue Mapping Table to New Codes

- Each year the MHS processes the newest CPT and HCPCS codes and identifies the associated revenue centers to link to each code in the series
- Each code can have up to 5 different revenue codes associated with it
- The Biller (using TPOCS) has the opportunity to choose the revenue code (different from commercial patient financial systems with a loaded Chargemaster)
- With CHCS – the first of the five revenue codes is what appears on the claim (automatically)

Linking Modifiers to Codes

- Modifiers can be found in both the CPT and HCPCS coding books
- Modifiers are appended to the CPT/HCPCS code
- The modifier is appended by Coding
- Two-digit numeric or alphanumeric characters in addition to CPT or HCPCS code to give additional information to third-party payers
- One of the top 10 billing errors determined by federal, state, and private payers involves the incorrect use of modifiers
- Examples of modifiers:
  - 51 – indicates multiple procedures were performed
  - 50 – indicates procedure was bilateral

When Are Modifiers Appropriate?

- When a service/procedure has both a professional and technical component – but both components are not applicable
- When a service/procedure was performed by more than one physician or in more than one location
- When a service/procedure has been increased or reduced
- When only part of a service was performed
- When a bilateral procedure was performed
- When a service/procedure was performed more than once
- When unusual events occurred
- When administering anesthesia – to identify patient's physical status

Understanding Modifiers

When to Use Them?

- It is important to validate the final modifier determination against the medical record documentation
- A modifier provides the means by which a physician or facility can indicate that a service provided to the patient has been altered by some special circumstances, but the code description itself has not been changed
- There should be pertinent information and adequate definition of the service/procedure performed that supports the use of the assigned modifier
- If service is NOT DOCUMENTED, or the special circumstance is not indicated, it is NOT considered appropriate to report the modifier

Modifier Scenarios

Example: Decision for Surgery (-57)

- After reviewing the patient's medical record, it is determined that the physician provided an E/M service that resulted in the decision for surgery on the same day as the surgical procedure
- Modifier -57 rules state: Add modifier -57 to the appropriate level E/M service that resulted in the initial decision to perform the surgery
  - Note: Some commercial third-party payers accept modifier -57 appended to E/M services that result in a decision for minor surgery

Incorrect Use of Modifiers

Example – Incorrect Use of This Modifier:

- Attaching modifier -57 to an element on the facility bill
- Reference the modifier list in the code book for modifiers not allowed for outpatient hospital facility billing
- It may be possible to use modifier -57 on a minor procedure (check w/your third-party payers on their definition of “minor”)

Modifiers for Evaluation & Management

One of the most common modifiers is -25:

SIGNIFICANT SEPARATELY IDENTIFIABLE E/M SERVICE BY THE SAME PHYSICIAN ON THE SAME DAY OF THE PROCEDURE OR OTHER SERVICE

- A significant, separately identifiable E/M service is defined or substantiated by documentation
- The E/M service may be prompted by the symptom/condition for which the procedure or service was provided
- CPT codes for use with modifier -25 are 92002–92014 and 99201–99499 (unless limited by the payer)

Codes for Professional and Technical Components

- There are other procedure/service codes that identify the technical component only, and codes that represent both the professional and technical components as complete procedures/services (called global service codes)
- Certain procedure codes describe and represent only the professional component portion of the procedure/service. These codes are stand-alone procedures and are identified by the provider's professional efforts
- When the physician component is reported separately, the service may be identified by adding modifier -26 to the usual procedure code
  - For modifier -26, the provider must prepare a written report that includes findings, relevant clinical issues, and, in some cases, comparative data; and this report must be available if requested by the payer

Appending Modifiers onto the Claim

- Modifiers expand the explanation of what happened during the episode of care
- Was a procedure done on only one side of the body?
- Was it on the right side or the left? (RT or LT)
- A modifier appended to the code for the procedure would help the payer to understand that it was done on one or both sides
- This can have a financial impact when a -50 modifier is used
- **Always follow your Service's guidance for appending modifiers. Coders typically append modifiers. Billers see payer requests for modifiers**

Knowing the Billing Rules

- It’s important to understand the data elements required for proper billing
- Knowing when to use certain data elements can be the difference between being paid or denied for a claim
- Know how and when to use Condition Codes and Occurrence Codes if required by a third-party payer
- Know when claims need to be reviewed by coding for modifiers because they are a billing requirement for payment

Understanding Present on Admission

- What is a Present on Admission (POA) Indicator?
- How is it linked to MS-DRGs?
- Why does it affect the MHS?
- When is it required for billing?
- How is the MHS complying with this requirement?
- Are any facilities exempt from POA?

Background on Present on Admission

What is the purpose of the Present on Admission (POA) indicator?

- Pre-Existing?

Or

- Hospital Acquired?

Background – DRA

Deficit Reduction Act of 2005 (DRA) required:

- …all acute-care facilities reimbursed under the DRG model must identify secondary diagnoses that are PRESENT ON ADMISSION at the time a patient is admitted
- In October of 2008, payment was impacted based on the presence of identified conditions NOT present at the time of admission

POA Defined

- A condition or diagnosis that is PRESENT at the time the order for inpatient admission is written
- Principal and secondary diagnoses
- Will identify hospital-acquired conditions and infections
- The goal is to improve hospital quality and identify and measure Patient Safety

What Are “Never Events”?

1. Object left in surgery
2. Air embolism
3. Delivery of incompatible blood products
4. Catheter-associated urinary tract infections
5. Decubitus pressure ulcers
6. Vascular catheter-associated infections
7. Mediastinitis after CABG surgery
8. Hospital-acquired injuries – Fractures, dislocations, intracranial injury
9. Crushing injury; burns

Identified in the FY 2008 – Inpatient Prospective Payment System Final Rule

Identifying Never Events with Codes

- PA – Surgical or other invasive procedure on wrong body part
- PB – Surgical or other invasive procedure on wrong patient
- PC – Wrong surgery or other invasive procedure on patient

Started in 2010 – Examples:

- E876.5 – Performance of wrong operation (procedure) on correct patient
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side/body part

POA Indicators & Definitions

The POA indicators and definitions for the inpatient record are:

- Y = Yes, the condition is present on admission at the time of the order to admit to inpatient status
- N = No, the condition is not present on admission, and it developed during the inpatient stay
- U = Unknown (not enough documentation in medical record) – coders may need to query the physician to seek clarification
- W = Clinically Undeterminable by Provider (physician)
- 1 = Exempt from POA reporting (this code is the equivalent code of a blank on the UB-04 claim form)

What the Documentation Will Reflect

- Was the condition present and diagnosed prior to the inpatient admission?
- Did the condition require any additional investigation?
- What were underlying causes of signs and symptoms?
- Was the condition suspected, possible, probable, or to be ruled out?
- Any external causes of injury or poisoning?
- Any acute and/or chronic status of condition(s)?

Outpatient to an Inpatient Status

What if the patient starts out in the Emergency Room and then is admitted?

- When an outpatient is admitted to inpatient status, the conditions documented for the outpatient encounter are considered to be present on inpatient admission
- Assign “Y” for these cases
- Diagnoses from ER are considered present on admission

Benefits of POA

- Will help payers to distinguish between conditions that were pre-existing at the time of admission and those complications that occurred during the stay
- Because the indicators will be evident on the claim, payers can track patient safety and quality-of-care measures
- Payers can then decide whether to withhold payment to hospitals with a large percentage of quality issues or reward those hospitals who are more careful with the quality of care

CMS Decided

- Medicare decided that they would no longer pay for the additional costs of certain preventable conditions – this included certain infections – that were acquired during the hospital stay
- They began collecting data back on 1 October 2007
- How soon until commercial third-party payers do the same?

What About Other Payers?

- We all know that CMS makes their decision and then, about a year or two later, the rest of the insurance industry adopts the same standard
- The same is true of POA
- Some third-party payers require that if you use MS-DRGs (the MHS does), you must submit the claim with the correct POA information on it

Billing and Reporting POA

- Paper Claims – the POA indicator is the eighth digit of Field Locator (FL) 67, Principal Diagnosis, and the eighth digit of each of the Secondary Diagnosis fields, FL A-Q
- Requirement is to report the applicable POA indicator (Y, N, U or W) for the principal and any secondary diagnoses and include this as the eighth digit
- Requirement says: Leave the field blank if the diagnosis is exempt from POA reporting (use a 1)

Tying Never Events to Payment

- CMS determined that they would not pay for adverse events and designed the POA (Present on Admission indicator) to capture whether condition was present on admission or acquired while in the hospital
  - Example: Patient is admitted for MI (myocardial infarction) and develops a pressure ulcer – CMS will pay for care related to the heart attack but not for the pressure ulcer

Example: Electronic Billing and POA

- Using the 837i, submit the POA Indicator in segment K3 in the 2300 loop, data element K301
- **<u>Example 1</u>**:

  POA indicators for an electronic claim with one principal and five secondary diagnoses should be coded as:

  POAYNUW1YZ

- **<u>Example 2</u>**:

  POA indicator for an electronic claim with one principal diagnosis without any secondary diagnosis should be coded as:

  POAYZ

MS-DRGs and POA

- Like DRGs, MS-DRGs are codes to classify and reimburse inpatient hospital stay
- The previous TRICARE DRG system had 555 codes
- The new TRICARE MS-DRG system has 745 codes (345 base codes)
- 3M TRICARE Grouper assigns an MS-DRG based on:
  1. ICD-9 diagnosis and procedure codes
  2. Age
  3. Gender
  4. Complications or co-morbidities

MS-DRGs and POA (cont'd)

Background Timelines:

- ✓ CMS adopted MS-DRG in FY08
- ✓ Many payers delayed implementation (including TRICARE)
- ✓ TRICARE Operations decided to implement MS-DRGs beginning with FY09
- ✓ TRICARE contract with 3M for TRICARE grouping software updates are linked and affect both Purchased Care and Direct Care

POA Data Flow

- SCR 4299 added the POA indicator to CCE data feed to CHCS
- SCR 4299 also covered the addition of POA to SIDR (Standard Inpatient Data Record)
- SCR 4299 also covered the addition of POA to UB-04 for inpatient billing

In Summary…

- Reviewed Revenue Codes/Occurrence & Condition Codes
- Reviewed modifier scenarios
- Covered the background of POA
- Examined “Never Events”
- Reviewed both the coding and billing requirements
- Examined examples of how both paper and electronic claims should be sent to the payer
- POA data flow for indicator to flow to the claim form properly

Questions

- Any questions?